Major Initiatives and Subprograms

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Major Initiatives and Subprograms

The N.C. Medicaid Program has developed a number of initiatives and subprograms over time to meet federal or State government mandates, to respond to recipient lawsuits, to meet specific medical needs identified among Medicaid recipients or to give recipients better access to care or more care options. Some of these are only available to specific groups of recipients, such as pregnant women, and some are available to all. Services under the various subprograms are not necessarily mutually exclusive; a recipient may be eligible to receive services from a number of subprograms.

Managed Care

Managed care options for Medicaid recipients are now available in all 100 North Carolina counties. As of June 2001, there were 672,304 Medicaid recipients enrolled in a managed care plan out of a total of 971,926 Medicaid eligibles, or 69 percent. Options include Carolina ACCESS, ACCESS II, ACCESS III, and Risk Contracting with State-licensed health maintenance organizations (HMOs). All managed care options operate under the authority of 1915(b) of the Social Security Act. Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Although recipients of Medicaid who are dually eligible for Medicaid and Medicare are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan. Managed care options are as follows:

- **Carolina ACCESS -** A primary care case management model (PCCM), characterized by a primary care physician gatekeeper.

- **ACCESS II and ACCESS III -** These programs build on the Carolina ACCESS program by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of health care. ACCESS II and ACCESS III, originally created as a health care demonstration project by the N.C. Office of Research, Demonstrations, and Rural Health Development, are currently a joint collaborative effort between DMA and this office.

- **Healthcare Connection** - A program operating in Mecklenburg County requiring mandatory enrollment in an HMO for a majority of Medicaid recipients in that county.

- **Risk Contracting -** DMA contracts with HMOs in selected areas to provide and coordinate medical services for certain Medicaid eligibles on a full risk-capitated basis. In these areas, recipients may choose between a participating HMO and Carolina ACCESS. The State must license all HMOs that contract with DMA.

For all of these healthcare models the objectives are:

- cost-effectiveness
- appropriate use of healthcare services
- improved access to primary preventive care

Maternity and Child Health Subprograms

Providing preventive medical services and basic medical care for mothers and children is a continuing priority for the Medicaid Program and for the State of North Carolina. Medicaid covered 40.5 percent of all deliveries in North Carolina during SFY 2000 (the most recent fiscal year for which population data were available). The number of births covered by Medicaid during SFY 2000 was 48,690 out of a total of 120,247 live births. Medicaid coverage is federally mandated for children with family incomes below 100 or 133 percent of the federal poverty level, depending on the age of the child. Over the years, North Carolina has taken advantage of federal options to expand Medicaid coverage to pregnant women and children with incomes ranging up to 185 percent of the poverty level. Since implementing the initiatives and programs described below, North Carolina has experienced many positive outcomes, including reductions in the infant mortality rate and better access to preventive health care for Medicaid recipients and low-income children.

- **Baby Love** – Baby Love was implemented in 1987 and is administered jointly by the DMA and the Division of Public Health. The program provides pregnant women with comprehensive care through an expanded Medicaid benefit package which includes childbirth and parenting classes, in-home nursing care for high-risk pregnancies, nutrition counseling, psychosocial counseling, and postpartum/newborn home visits. Specially trained nurses and social workers called Maternity Care Coordinators assist the women in accessing medical care and support services. In addition, Maternal Outreach Workers, who are specially trained to assist at-risk families, are available in 58 counties.

  Evaluations of the Baby Love Program have shown that women who receive Maternity Care Coordinator services average more prenatal visits per pregnancy, have a higher participation rate in the WIC program, experience better birth outcomes, and are more likely to receive postpartum family planning services. Likewise, their children are more likely to receive well-child care and WIC services.

- **Health Check –** In 1993, North Carolina expanded the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to form Health Check. Health Check encourages regular preventive health care and the diagnosis and treatment of any health problem detected during a screening**.** Medicaid recipients under the age of 21are automatically eligible for Health Check services.

  An integral part of the Health Check Program is a special initiative called the Health Check Outreach Project. Specially trained Health Check Coordinators work through this program to reduce barriers and educate families on the importance of preventive health services. Recently, a plan was endorsed by the N.C. Health Directors' Association to expand Health Check Coordinators statewide. This plan will eventually place Health Check Coordinators in all counties by reallocating existing

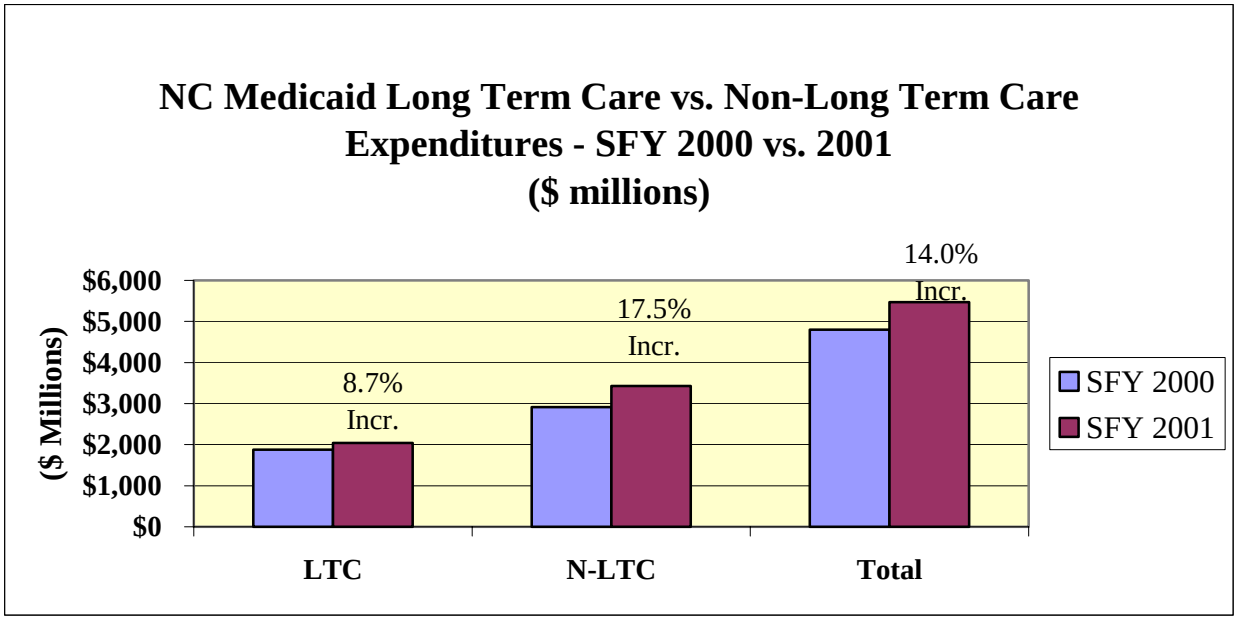
positions. Health Check Coordinators are located in 76 counties as well as the Qualla Boundary. DMA's Managed Care Section is the administrative entity for the Health Check Program and coordinators. The Managed Care Section works closely with the Division of Women and Children's Health to provide guidance to the counties.

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following the health care activities of Medicaid-eligible children. It enables Health Check Coordinators to determine which Medicaid-eligible children in their respective counties are receiving regular and periodic Health Check screenings, immunizations, and referrals for special health care problems. AINS generates notices to the parents of Medicaid-eligible children, notifying them of the Health Check Program, scheduled screening appointments, missed appointments, immunizations, and available programs and services. For children enrolled in a Medicaid managed care program, the name of the Carolina ACCESS primary care provider or the HMO appears on letters sent to providers to whom referrals are being made. Access to and utilization of health care services for Medicaid-eligible children and youth have improved since the program was initiated.

- **Health-Related Services for Children** – In order to assure that a comprehensive array of services is accessible to children, Medicaid pays for physical therapy, occupational therapy, audiological services, speech/language services, and psychological services for children in public schools and Head Start programs. These services are provided to eligible children through Local Education Agencies (LEA's) and local Head Start programs. In addition, North Carolina has an Independent Practitioner Program, which enrolls and reimburses individual independent practitioners to provide physical therapy, occupational therapy, respiratory therapy, speech and language therapy, and audiological services to children from birth through 20 years of age.

Long-term Care

N.C. Medicaid spends a large portion of its service dollars (approximately 37 percent) on long-term care. Long-term care includes nursing facility care, intermediate care facilities for the mentally retarded (ICF-MR), adult care home personal care services, and a variety of home and community-based services. During SFY 2001, 95,376 people received Medicaid long-term care services in North Carolina. As shown on the next page, long-term care during SFY 2001 cost a total of approximately $2 billion, an increase of 8.7 percent over the previous year. The average cost per recipient was approximately $21,400 for the year.



Institutional Care Services:

Nursing Facility Care - There are times when nursing facility care is the best option for Medicaid recipients. All Medicaid certified nursing facilities are required to provide skilled nursing (SN) and intermediate care (IC). Nursing facility reimbursement rates differ based on whether a resident requires skilled or intermediate level of care. In SFY 2001, a total of 26,128 Medicaid recipients received skilled care in nursing facilities costing $403,691,200. A total of 23,245 recipients received intermediate care costing $436,964,073.

All Medicaid recipients must receive prior approval before admission to a nursing facility. Prior approval is given only if recipients meet the State's stringent medical criteria for admission. There is also a federal requirement for pre-admission screening and annual resident review (PASARR) to screen and evaluate applicants and residents of Medicaid certified nursing facilities for mental illness, mental retardation, developmental disabilities, and related conditions.

Medicaid allows an individual with a spouse living in a nursing facility to keep a larger portion of the couple's income than normally allowed under Medicaid eligibility rules. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The income of the spouse living at home is considered in determining whether an allowance is budgeted. The total income and resources amount that may be protected for the at-home spouse increases each year.

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) – ICF-MR facilities are long-term care facilities for the mentally retarded/developmentally disabled that meet certain federal criteria. The criteria include the need for active treatment for individuals that have mental retardation or a related condition and who have a severe, chronic disability. ICF-MR facilities must meet certification requirements relating to the provision of habitable services as well as basic intermediate care services. ICF-MRs are paid prospective per diem rates.

Adult Care Home Personal Care Services – In 1995, N.C. Medicaid began covering personal care services for residents in adult care homes who are eligible for Special Assistance for Adults (SA) and Medicaid (see the "Personal Care Services" subsection below for a description of personal care services in the home). In 1996, Medicaid expanded this coverage by creating "enhanced" adult care home personal care and adult care home case management services for residents of adult care homes who met Medicaid criteria for being a "heavy care" resident. The Adult Home Personal Care Services Program served 27,870 residents in SFY 2001 for a total expenditure of $109 million.

Home and Community-Based Services:

Home and community-based long-term care is a cost-effective and preferable alternative to institutionalization. Medicaid recipients can receive several home-based services such as home health, personal care services, adult care home services, home infusion therapy, and hospice.

Home Health Services – Medicaid covers visits provided by certified home health agencies for skilled nursing, physical therapy, speech-language pathology services, occupational therapy and home health aide services when the home is the most appropriate setting for the care. Medical supplies such as adult diapers, disposable bed pads, catheter and ostomy supplies are also covered under home health. Agencies are paid the lower of their customary charge to the general public or a maximum per visit rate established by DMA for each service.

Community Alternatives Program (CAP) - North Carolina operates four Community Alternatives Programs as another option for home and community care as a cost-effective alternative to institutionalization. These are known as "waiver" programs because standard program requirements are waived to allow the program to operate. The waiver programs provide some services that otherwise are not covered under Medicaid.

- **Community Alternatives Program for Disabled Adults (CAP/DA) -** CAP/DA provides a package of services to allow adults, age 18 and older, who qualify for nursing facility care, to remain in their private residences. CAP/DA experienced significant growth for many years as DMA pushed its expansion into all counties and fostered the growth of existing county programs. The effort received significant assistance from Duke's Aging at Home Program with an investment of more than $2 million from the Kate B. Reynolds Charitable Trust. The Aging at Home Program and the Reynolds Charitable Trust started supporting CAP/DA expansion in 1994 by providing grants to four counties to start CAP/DA programs and one county to expand its program. In 1995, they offered grants to start CAP/DA to the twelve remaining non-CAP/DA counties. CAP/DA went statewide in January 1996. The Aging at Home/Reynolds Charitable Trust effort had a third stage in which grants went to 18 counties to expand CAP/DA. CAP/DA has been the state's primary answer to controlling the growth of nursing facility expenditures while addressing quality of life issues for the expanding frail elderly population. It offers North Carolina the only significant avenue for addressing Olmstead issues for the frail

elderly and physically disabled adults. The program served approximately 11,741 people in SFY 2001 at less cost than nursing facility care. The average monthly cost per recipient of CAP/DA services was approximately 75 percent of that of care at a Medicaid nursing facility.

- **Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD)** - CAP-MR/DD is a special Medicaid home and community-based "waiver" program. It was implemented in 1983 to serve individuals who would otherwise qualify for care in an ICF-MR. It allows these individuals the opportunity to be served in the community instead of residing in an institutional or group home setting. The Medicaid cost for community care must be cost effective in comparison to the cost of ICF/MR care. The Division of Mental Health , Developmental Disabilities, and Substance Abuse manages the daily operation of the program under an agreement with DMA. The program is available statewide through local area mental health, developmental disabilities ,and substance abuse programs. CAP-MR/DD served approximately 6,121 people in SFY 2001 at an average monthly cost per recipient of approximately 44 percent of the average cost of ICF-MR care.

- **Community Alternatives Program for Children (CAP/C) -** CAP/C provides home-based care for medically fragile children through age 18 who would otherwise require long-term hospital care or nursing facility care. Approximately 356 children participated in CAP/C in SFY 2001. The program contributed to the quality of life for the children and their families/caregivers, while providing care that was cost effective in comparison to the Medicaid cost for institutional care.

- **Community Alternatives Program for Persons with AIDS (CAP/AIDS)** - CAP/AIDS offers a home care alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive with other qualifying conditions. CAP/AIDS is a cooperative effort with the Division of Public Health's AIDS Care Unit. The AIDS Care Unit administers the program with DMA providing oversight. This program began in late 1995 and is still developing statewide. Approximately 28 people were served in SFY 2001 at a significantly lower average cost than the average Medicaid cost of nursing facility care.

Overall, CAP has been very successful in giving individuals an alternative to living in an institution, while containing costs to the Medicaid program. The programs have allowed those who otherwise would be institutionalized to remain with their family in familiar surroundings. All of these benefits cost Medicaid less than institutional care.

Personal Care Services (PCS) –PCS covers personal aide services in private residences to perform personal care tasks for recipients who, due to a debilitating medical condition, need help with such basic personal activities such as bathing, toileting, and moving about. Aides also monitor the patient's vital signs. Services may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's basic personal health. PCS is provided for the patient according to a physician's authorized plan of care. A recipient may receive up to

80 hours of PCS in a calendar month. During SFY 2001, a total of $113 million was spent on 21,121 PCS recipients.

Home Infusion Therapy (HIT) –HIT is for recipients who live in a private residence or adult care home. Coverage is for self-administration of a drug or nutrition therapy. The recipient or an unpaid caregiver may administer the therapy after appropriate training.

Private Duty Nursing (PDN) –PDN coverage is for recipients who live in a private residence and require substantial and complex continuous nursing care as ordered by the attending physician. PDN must have prior approval, which may include a visit to the recipient's home to verify the medical necessity for the service.

Hospice – Hospice is a package of medical and support services for terminally ill patients with a medical prognosis of a six month or less life expectancy. Services are provided in a private residence, adult care home, hospice residential care facility or a hospice inpatient unit. They may also be provided in a hospital or nursing facility under arrangement with the hospice agency.

Durable Medical Equipment (DME) - Medicaid pays for DME when it is medically necessary for a recipient to function in their home or an adult care home. The list of covered items includes wheelchairs, hospital beds, blood glucose monitors, bedside commodes, oxygen and respiratory equipment. Orthotic and prosthetic devices, including braces and artificial limbs, are covered for recipients from birth through age 20. The patient's physician must order DME and document medical necessity on the Medicaid Certificate of Medical Necessity and Prior Approval form. Some items require prior approval. All DME and related supplies have established lifetime expectancies and quantity limitations.

Behavioral Health

N.C. Medicaid covers a variety of services for behavioral health, some under the rehabilitation option and others under the clinic option. Services provided under the rehabilitation option are provided by Area Mental Health Centers and include Outpatient Therapy, Psychological Testing, Day Treatment, Partial Hospitalization, Psychosocial Rehabilitation, Facility-Based Crisis, and Community-Based services for recipients of all ages and Residential services for recipients under the age of 21. Clinic services include Outpatient Therapy and Psychological Testing provided by directly enrolled providers and LEAs. Medicaid also covers inpatient psychiatric care in psychiatric units for recipients of all ages and in free-standing psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTFs) for recipients under the age of 21. Inpatient services, residential services, and outpatient therapy must go through a prior approval process.

DMA also provides services in ICF-MRs, which are long-term care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. Please see the "Intermediate Care Facilities for the Mentally Retarded (ICF-MR)" subsection of the "Long-Term Care" section of this report.

Dental Health

N.C. Medicaid covers most general dental services such as diagnostic exams and radiographs, and preventive services such as dental cleanings, fluoride treatments, and sealants. Restorations, surgeries, and partial and full dentures are covered as well as orthodontic services for children up to age 21. Most dental services do not require prior approval. Except where a coverage category is exempted from copays by law, recipients are charged a $3 copayment per visit. A special children's initiative effective February 1, 2001, allows children from birth to age three to receive special preventive dental services provided by physicians in an attempt to decrease the incidence of early childhood caries and improve access to dental care.

Pharmacy

Prescription drugs and Insulin (where the manufacturers have signed a rebate agreement with CMS) are covered under the pharmacy program. Recipients may have up to six prescriptions per month and are locked into one pharmacy provider during the month of service. A recipient copayment of $1 applies for both generic and brand medications. N.C. Medicaid does not pay for a drug to be refilled during the same month that the prescription is originally filled. Recipients may have a 100-day supply of their medication. The pharmacy reimbursement fee structure is as follows: AWP (average wholesale price) – 10 percent, State MAC, Federal Upper Limit or Usual and Customary, whichever is lower, plus a dispensing fee of $5.60 per new prescription.

Visual Services

The Visual Services Program within the Medical Policy Section of DMA is responsible for the overall administration of visual services covered in the N.C. Medicaid Program. Medicaid covers medical eye examinations, corrective eyeglasses, medically necessary contact lenses, and other visual aids. Prior approval is required for all visual aids and various optical services/exams. There are limitations regarding the frequency of doctor visits and the number of dispensed visual aids during specific eligibility periods. A $3 copayment is applicable to ophthalmologist visits, while a $2 copayment applies to optometrist visits. Although a $2 copayment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Through a contractual agreement, Medicaid eyeglasses are supplied through the Department of Correction’s Nash Optical Plant, located in Nashville, North Carolina. Providers must obtain Medicaid eyeglasses through this laboratory unless, due to extenuating circumstances, prior approval is granted.

Hearing Aid Services

Single and binaural hearing aids are covered once every four years for Medicaid recipients under 21 years of age. FM systems are covered for preschool children ages 4

and above. An ENT specialist, otologist or otolaryngologist must submit a prior approval request, accompanied by an audiological report, documenting the medical necessity of any prescribed hearing aid. Exceptional requests for replacement or new aids due either to breakage that is not covered by manufacturer warranty, loss of aid or recipient growth also require prior approval. There are no copayments for hearing aids or hearing aid services.

Medicare-Aid

In February 1989, North Carolina began a new limited Medicaid program for Qualified Medicare Beneficiaries. The program, known as Medicare-Aid, provides assistance to eligible individuals with Medicare cost-sharing expenses, such as deductibles, premiums, and coinsurance charges. The eligibility income limit for Medicare-Aid is 100 percent of the federal poverty level. This level is adjusted in April of each year.

Effective January 1, 1993, the Medicare-Aid program was expanded to include qualified individuals with income greater than 100 percent of the federal poverty level but not greater than 120 percent. These individuals are referred to as Specified Low-Income Medicare Beneficiaries. Eligible individuals in this group receive assistance with the payment of their Medicare Part B premium only.

In January 1998, the Medicare-Aid program was further expanded to in include two new groups of Medicare beneficiaries. Eligible individuals with incomes between 120 percent and 135 percent of the federal poverty level receive assistance with the payment of their Medicare Part B premiums. Individuals with incomes between 135 percent and 175 percent of the federal poverty level receive reimbursement for a portion of the cost of their Medicare Part B premium. The reimbursement amount is set annually by CMS. These two groups are referred to as Qualifying Individuals. Funding for these groups is capped and approval of assistance is based on a first-come first-serve basis.

During SFY 2001, 39,949 recipients benefited from Medicare-Aid. Total cost for this coverage was $18,913,874.

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This annual report was produced by the
North Carolina Department of Health and Human Services
Division of Medical Assistance
August 2002

The main body of this report may be accessed in its entirety in a PDF format at our website http://www.dhhs.state.nc.us/dma/ under the “Publications” link.